

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023632

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 145

FILED JUN 24 1963

| | | | |
|---|---|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PLATTE</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u> | | c. CITY OR TOWN <u>KANSAS CITY, MO</u> | |
| Length of stay in 1b <u>11EE</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORIAL HOSPITAL</u> | | d. STREET ADDRESS (If outside, give location) <u>6901, N.W. 78th, Street</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>DENNEY JAYNES DOLLAR</u> | | 4. DATE OF DEATH Month Day Year <u>JUNE 18 63</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/16/63</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (City and state or country) <u>North Kansas City U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>TRUMAN DOLLAR</u> | | 13b. MOTHER'S MAIDEN NAME <u>DONNA SUE JAYNES</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>None</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | |
| 16. SOCIAL SECURITY NO. <u>[REDACTED]</u> | | 17. INFORMANT Address <u>Truman Dollar, 6901, N.W. 78th, Street</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | |
| DUE TO (b) <u>Congestive Heart Failure</u> | | | |
| DUE TO (c) <u>Congenital Heart Defect</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | |
| PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from <u>6-17-63</u> to <u>6-18-63</u> and last saw her alive on <u>6-18-63</u> Death occurred at <u>1am 6-18-63</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Bernard H. Mullins M.D.</u> | | 22b. ADDRESS <u>1806 Swift St. No 15C/6m</u> | |
| 22c. DATE SIGNED <u>6-18-63</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | |
| 23b. DATE <u>6/19/63</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylan Antioch Chapel</u> | |
| 25. DATE RECD. BY LOCAL REG. <u>6-18-63</u> | | 26. REGISTRAR'S SIGNATURE <u>Marguerite Audena</u> | |
| 3325 Vivion Rd. K.C. 19. Mo (Licensed Embalmer's Statement on Reverse Side) | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

1 6004

2 0838

3

4 0

5 0

6

7 0

8 1

9 754.5

10

11

12 6-0

13 2-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James E. Hackleman

Licensed Embalmer No. 4573

P. O. Address H. C. 9760

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.